Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ Gender: M F 

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single  Married Separated  Divorced  Widowed 

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Health Care Provider you are seeing:**

Date                     Name and Type (MD, DO, DC, etc)      Results

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Feet:Inch   Weight:\_\_\_\_\_\_\_\_\_\_ lbs Handedness: Rt\_\_\_  Lt\_\_\_\_

**Why are you seeking chiropractic care:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

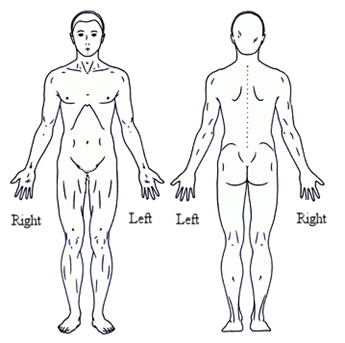
**When and how did this start?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this interfere with your: Sleep Work Daily Activities 

On a scale from 1-10, 1 being no pain, rate your pain today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes it worse? \_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mark where you are experiencing symptoms**

**Describe your condition:**

Constant    Comes & Goes Localized Radiating 

Numb/Tingling  Stabbing/Sharp Burning        Ache 

**Do you have difficulty**:

Sitting      Standing  Bending forward  Bending Backwards 

Walking Lifting     Reaching overhead    Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to work or auto accidents? Y N 

Are you in litigation for any accidents? (Auto, Worker’s Comp, etc) Y N 

Is there anything else the Doctor or Staff should know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Y N Diabetes

Y N High Blood Pressure

Y N Heart Disease

Y N Musculoskeletal Disease

Y N Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Stroke/aneurysm

Y N Osteoporosis

Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current General History**

Y N Unexplained Wt Change, Inc or Dec.

Y N Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Bleeding/Bruising

Y N HIV

Y N Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Insomnia

Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Endocrine History**

Y N Thyroid Condition: Hyper/Hypo

Y N Diabetes

Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eye/Ear/Nose/Throat**

Y N Eye or Ear Pain

Y N Other Visual Conditions

Y N Change in vision/hearing/taste

Y N Ringing in Ears

Y N Dizziness

Y N Difficulty Chewing/Swallowing

**Gastrointestinal System**

Y N Anorexia/Bulimia

Y N Constipation/Diarrhea

Y N Nausea/Vomiting

Y N Abdominal Pain/Swelling

Y N Gallbladder Disease

Y N Liver/Pancreatic Disease:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary System**

Y N Urinary Urgency/Pain

Y N Difficulty holding/expelling

Y N Kidney Disease/Stone/Pain

Y N Prostate Issues

Y N Pelvic Pain

**Cardiovascular System**

Y N Heart Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Past heart or vascular disease

Y N Chest discomfort/pain

Y N Palpitations

Y N Edema

Y N High blood pressure

Y N Blood clot/aneurysm/DVT

Y N Sudden calf pain with walking

Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin/Hair/Nails**

Y N Skin Cancer

Y N Rashes/itching/lesions

Y N Psoriasis

**Neurological System**

Y N Headaches

Y N Seizures/epilepsy

Y N Vertigo

Y N Loss of sensation

Y N Head Trauma

Y N Multiple Sclerosis

Y N Vertebral Disc Condition

Y N Anxiety/Bipolar/Depression

**Musculoskeletal System**

Y N Osteoporosis/Fibromyalgia

Y N Arthritis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Scoliosis

Y N Joint pain/stiffness/swelling

Y N Muscle cramp/soreness/pain

Y N Neck pain

Y N Upper/Mid back pain

Y N Low back pain

Y N Shoulder/arm/hand pain

Y N Leg/knee/foot pain

Y N Fractures/dislocation/sprains

Y N TMJ issues

**Pulmonary System**

Y N Asthma/Shortness of Breath

Y N Apnea

Y N Pneumonia

Y N Cigarette Smoking

Y N Respiratory Infections

Y N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Implants/Orthotics**

Y N Cardiac/Pacemakers

Y N Joint replacement/Pins/plates/screws

**Diet/Exercise**

Y N Consume caffeine

Y N Consume alcohol

List any surgeries/hospitalizations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications/supplements:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Chiropractic Care**

* I understand that my health records are the property of Dynamic Chiropractic LLC and will be protected under HIPAA. At any time, I have the right to request a copy of my health records which will have a fair material value fee to copy.
* I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office’s privacy notice entitled “Notice of Privacy Practices”. I understand that I may review this notice at any time prior to signing this form.
* I authorize Dynamic Chiropractic to release information to any health care provider I am seeing and / or insurance company. I understand that any all payments are inherently my responsibility. I agree to my insurance company to be billed for payment and that I accept responsibility for what my insurance company may not cover. I agree to pay any balance associated with my care.
* I give my permission for my Doctor and/or staff to communicate by telephone or email regarding matters of chiropractic care, appointment reminders or scheduling.
* A parent must accompany his/her minor child on the first visit to Dynamic Chiropractic and sign a consent to treat minor for any additional visits where the Parent/Guardian will not be present.
* I authorize Dynamic Chiropractic to administer care as needed, as indicated from examination findings. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain every risk and complication, but I will rely on the doctor’s best judgement to protect my best interests. No Guarantees of cure have been implied or given.
* The Doctor of Chiropractic will discuss any further risks inherent for my case. I understand that I am an active participant in my chiropractic care and that I am encouraged to bring up questions or express any concerns.
* Out of respect to the doctors as well as fellow patients in the office, if you need to reschedule or cancel an appointment, you can do so via our website. I acknowledge that if I do not call and do not show for my appointment there will be a $20 no-call no-show fee that will be applied to my account. Follow up visits will not be scheduled until the balance has been paid.
* I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent to Chiropractic Care above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian’s Signature               Date Doctor Signature                            Date